Uplizna (inebilizumab-cdon)Infusion orders:

Name:______________________ DOB:___________ M ○ F ○

Phone #1 :_____________(H/W/C) Phone #2:______________(H/W/C)

ICD-10 code:____________ Weight kg____________

Years with Disease:

Prescriber must indicate the following requirements have been met (please provide documentation)

☐ Quantitative immunoglobulins within normal limits ☐ Latent TB screening negative
☐ Anti-aquaporin-4 (AQP4) antibody positive (required) ☐ HBV screening negative

If any the above are not checked, attach treatment/consultation notes clearing patient for inebilizumab-cdon therapy.

Therapy Orders

☐ Induction: Administer 300 mg Uplizna (inebilizumab-cdon) IV followed 2 weeks later by second 300 mg infusion

☐ Maintenance: Administer 300 mg every six months (starting 6 months from the first infusion)

☐ Nursing per WTDDC/SPI Procedures (including reaction management)

Needed documents:

☐ Recent Office notes (along with any therapies tried and outcomes)
☐ Current Medication List History, ☐ Physical Report (w/in past 6 months)
☐ Lab Results, ☐ Demographic Sheet, ☐ Insurance Cards (front and back)

ORDERING PROVIDER
Signature____________________________ Date________________

Provider _________________________ Phone_____________ Fax_________

Please **FAX** form and documents needed to **1-806-302-1241 (dial "1")**